

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026241

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6565

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUN 28 1963

1. PLACE OF DEATH

a. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION De Paul HospitalInside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY

c. CITY
OR TOWN St. Louis,Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
4936 MaffittReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Mary

Middle

J.

Last

O'Connell

4. DATE OF DEATH

Month

June

Day

21,

Year

1963

5. SEX
F6. COLOR OR RACE
W7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐8. DATE OF BIRTH
5-10-18729. AGE (last birthday)
91IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none10b. KIND OF BUSINESS OR INDUSTRY
-----11. BIRTHPLACE (City and state or country)
Knockeenahone, Ireland12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

James O'Connell

13b. MOTHER'S MAIDEN NAME

Susan Triss

14. NAME OF HUSBAND OR WIFE

single

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Catherine Barrett 4936 Maffitt Pl.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cachexia Insentim (Ch)

INTERVAL BETWEEN
ONSET AND DEATH
Weeks

DUE TO (b)

Anterior Schrotin Heart Disease Ch

DUE TO (c)

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Semiility

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 21 1963 and last saw her alive on June 21 1963
Death occurred at June 21 1963 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

6-24-1963

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Mo.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

JUN 24 1963

26. REGISTRAR'S SIGNATURE

Road Smith. M.O.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Francis Williamson

Licensed Embalmer No.

3565

P. O. Address

3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.